JUST FOLLOWING ORDERS

To the editor:
At the August 2004 AANA Annual Meeting, in Seattle, Wash, Gene Blumenreich, JD, AANA General Counsel, was given a special recognition award for his work on behalf of the profession of nurse anesthesia. In his December 2004 “Legal Briefs” column, 1 Mr Blumenreich confirms the wisdom of that award and is worthy of another.

Never have I seen so clearly or persuasively argued a point that must be forcefully brought home to every student and practitioner of nurse anesthesia. I hope you will allow me the space to repeat his advice:

It is difficult to know what to do when ordered by a physician to take an action that you know to be wrong or damaging. ... However, the AANA Code of Ethics and a review of legal cases make clear: Don’t just go along! Don’t just record it in the record! Protest! Call for help! And just don’t do it!

In the context of the legal cases and discussion Mr Blumenreich presents to support this admonition, the effect is overwhelming. Every CRNA who reads this article (and we should all do our best to see that every CRNA we know does so!) will renew his or her vow to be the advocate our patients and our profession expect us to be.

CRNAs are fortunate indeed to have at their service the knowledge and passionate intelligence of Mr Blumenreich. It is my hope that as CRNAs we may all live up to his faith in us and try to match his commitment to excellence.

REFERENCE

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DIAGNOSIS AND TREATMENT OF NEGATIVE PRESSURE PULMONARY EDEMA IN A PEDIATRIC PATIENT

To the editor:
In regard to the October 2004 AANA Journal article, 1 I think an important adjunct for 100% prevention of negative pressure pulmonary edema was omitted. That is, the atraumatic insertion of a plastic oral airway into the patient’s mouth just prior to her emergence from general anesthesia. Oral airways come in sizes 50, 60, and 70 mm for children, and 80, 90, and 100 mm for adults. 2-4 The oral airway can be immediately removed when the patient is able to respond to commands to open his or her mouth.

Not only will the occlusion of the oral endotracheal tube never occur, but the anesthetist also will have the added advantage of an already-present mechanical airway adjunct, once the endotracheal tube is removed. The oral mucosa and the tongue are prevented from occluding the patient’s airway. This is especially important in the spontaneously breathing, somewhat somnolent patient.

Many anesthetists have concerns about damage to the dentition by an oral airway, and this has hampered some anesthetists from their routine use. One must carefully document the patient’s oral condition in the chart preoperatively during the patient’s airway assessment. Any concerns you may have, such as loose, chipped, or missing teeth; damaged restorations; and damaged partial or full dentures, should also be discussed with the surgeon, the patient, and the patient’s family as appropriate. The anesthetist should consider that many hard foods that the patient bites into are much harder than the plastic of the oral airway, and one must weigh this against the harmful patient consequences of negative pressure pulmonary edema.

Finally, there have been reports of glottic edema caused by prolonged use of the oral airway. 2-4 Again, this can be prevented by careful atraumatic insertion of the oral airway just prior to the patient’s emergence, with its immediate removal when the patient is able to “give up” the oral airway during postextubation.

REFERENCES:

Allan J. Schwartz, CRNA, DDS
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Response:
Allan Schwarz, CRNA, DDS, makes an excellent point concerning the insertion of the oral airway, as long as there has been documentation of a preoperative assessment of the patient’s oral condition in the medical record whereby insertion of an airway would not cause damage. Point taken.

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LETTERS
The use of the laryngeal mask airway with mechanical positive pressure ventilation

To the editor:

We are writing in regard to the October 2004 AANA Journal article, “The use of the laryngeal mask airway with mechanical positive pressure ventilation.” While the authors have advanced the case for the use of the laryngeal mask airway (LMA), we feel that they have only minimally reviewed the potential risks and current controversy concerning its appropriate use.

The article cites a 1998 review stating that in “several million cases...the risk of aspiration and gastric insufflation with an LMA is the same as that for the ETT.” One must consider the data sources for this review that is now more than 6 years old. From the introduction of the LMA in general practice in the late 1980s through the mid-1990s, anesthesia providers carefully followed Brain’s original absolute contraindications for LMA use including obesity, hiatus hernia, pregnancy, and history of gastrointestinal reflux, heartburn, ileus, and any other condition considered “full stomach” including diabetes mellitus, previous upper gastrointestinal surgery, trauma, anxiety, and pain states. Other contraindications included surgery that required Trendelenburg or lithotomy positioning due to the concomitant increases in intragastric pressure. Since that time, however, clinical practice is replete with the use of the LMA in nearly all of the above scenarios. Therefore, the data from these early reviews do not reflect current practice patterns or the rising prevalence of adult obesity to 35% of the total population.3

Keller et al recently reported 3 cases of aspiration associated with the use of the LMA, resulting in 1 death and 1 brain injury. All 3 patients had contraindications for LMA use: the first had a history of gastric surgery and was placed in lithotomy position; the second was morbidly obese (body mass index, 35 kg/m²), diabetic, and had previous gastric surgery; and the third was obese (body mass index, 32 kg/m²) and had an “asymptomatic” hiatal hernia. The accompanying editorial to this report points out that incidents of regurgitation and/or aspiration likely are not reported in the literature due to (1) fear by the anesthesia provider that they will be considered negligent, (2) legal authorities disallowing reporting until the case is settled, or (3) editor’s decision not to publish such reports judging the case to be malpractice. This implies that literature reviews may not accurately reflect the extent of this problem. We know of 2 cases of aspiration resulting in death in our practice area that will never be published, in particular, because they occurred in private practice and such cases generally are not submitted for publication.

In addition, we are puzzled by the authors’ directive that “muscle relaxants...should be used upon induction of anesthesia” for LMA placement based on 2 citations.6 7 The cited authors point out that inadequate depth of anesthesia is the primary cause of gagging, coughing, or laryngospasm during LMA insertion. Certainly paralyzing the patient will ameliorate these responses but just because it can be done does not mean that it should be done. Light anesthesia and the use of neuromuscular blocking agents has been implicated as a cause of intraoperative awareness.8 Therefore, it would seem prudent to provide an adequate level of general anesthesia before inserting the LMA rather than advising the routine paralysis of the patient.

Although we do not agree, we understand that there is a developing clinical consensus that the use of the LMA is “safe” in many scenarios that were previously considered a contraindication for mask askepsis. However, anesthesia providers must be certain that they are not compromising patient safety in so doing. Anecdotal reports of “safe use” based on one’s own experience are equivalent to the ethical position that it is acceptable to steal as long as you don’t get caught! We prefer to wait for the accumulation of a large body of current evidence before altering our use of this convenient, unprotected airway device. In addition, we believe that an anesthesia provider is obliged to err on the side of caution; one must carefully consider the characteristics and comorbidities of each individual patient in order to prevent patient injury.

REFERENCES


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Editor’s Note:
The authors have declined to respond to the letter from Villars et al.